



October 4, 2023

The Honorable Jason Smith  
Chairman  
House Ways & Means Committee  
1100 Longworth House Office Building  
Washington, D.C. 20515

The Honorable Richard Neal  
Ranking Member  
House Ways & Means Committee  
1100 Longworth House Office Building  
Washington, D.C. 20515

Re: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith and Ranking Member Neal:

The American College of Radiology (ACR®) appreciates the opportunity to respond to the committee's Request for Information on Improving Access to Health Care in Rural and Underserved Areas announced September 7, 2023. ACR represents more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists.

### **Sustainable Provider and Facility Financing**

Congress has taken action to mitigate some of the recent Medicare Physician Fee Schedule (MPFS) cuts on a temporary basis, however, reimbursement continues to decline. According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, Medicare payments to clinicians have declined by 26% from 2001-2023.<sup>1</sup> Recent data published by the Harvey L. Neiman Health Policy Institute echoes the AMA analysis finding that radiologist reimbursement for imaging provided to Medicare patients declined 25% from 2005-2021 when adjusted to 2021 dollars.<sup>2</sup>

ACR supports the Strengthening Medicare for Patients and Providers Act, H.R. 2474, which was introduced by Representatives Raul Ruiz, MD (D-CA), Larry Bucshon, MD (R-IN), Ami Bera, MD (D-CA) and Mariannette Miller-Meeks, MD (R-IA). This bill would add a permanent, Medicare Economic Index (MEI)-based inflationary update to the MPFS— providing much needed stability to the Medicare payment system— as our members contend with an increasingly challenging environment providing Medicare beneficiaries with access to timely and quality care. The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and a paucity of available alternative payment model/value-based care models, clearly demonstrates the Medicare

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<sup>1</sup> <https://www.ama-assn.org/system/files/medicare-updates-inflation-chart.pdf>

<sup>2</sup> Harvey L. Neiman Health Policy Institute; Budget Neutrality and Medicare Physician Fee Schedule Reimbursement Trends for Radiologists, 2005 to 2021; [https://www.jacr.org/article/S1546-1440\(23\)00521-5/fulltext](https://www.jacr.org/article/S1546-1440(23)00521-5/fulltext)

payment system is broken. The addition of an inflationary update will provide budgetary stability as clinicians—many of whom are small business owners—contend with a wide range of shifting economic factors, such as increasing administrative burdens, staff salaries, office rent and purchasing of essential technology. We urge the Committee to support H.R. 2474.

In addition to Medicare payment cuts and a lack of an inflationary update to the MPFS, physicians are facing another impending financial challenge with the implementation of Healthcare Common Procedure Coding Systems add-on code G2211, initially included in the CY 2021 MPFS final rule as one of two policies finalized for implementation that substantially increased payments to primary care and other specialties that frequently bill office-based evaluation and management (E/M) codes. The first was a major overhaul of all outpatient/office E/M codes, which reduced documentation burdens and increased the values to account for the continuous patient care and complexity associated with these visits. The second was the introduction of the G2211 add-on code, an unnecessary, duplicative, CMS-generated code also intended to capture the perceived additional complexity associated with primary care services. The G2211 add-on code was finalized despite major objections from the clinician community, the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), and the Medicare Payment Advisory Commission (MedPAC).<sup>3</sup>

As a result of these code changes MPFS expenditures were estimated to increase by over \$11 billion,<sup>4</sup> requiring CMS to reduce the CY 2021 conversion factor (CF) to comply with Medicare’s budget neutrality requirements. While primary care and other office-based specialties were slated to realize significant payment increases resulting from these code changes (irrespective of the reductions to the CF), many specialties — including those physician and non-physician clinicians who rarely, if ever, bill E/M — were slated for corresponding steep payment cuts associated with the application of budget neutrality.

Recognizing that cuts of this magnitude were unsustainable and could jeopardize patient access to care, in the Consolidated Appropriations Act, 2021 (CAA), Congress provided funds to mitigate these cuts, increasing the 2021 MPFS CF by 3.75%. Congress also postponed the implementation of G2211 until at least 2024.<sup>5</sup>

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<sup>3</sup> In its [comment letter](#) on the CY 2020 MPFS proposed rule, MedPAC noted that it did “not support the creation of a new add-on code” because the code was no longer necessary since the agency decided to maintain Level 2-5 E/M codes. MedPAC stated in the letter that because clinicians can use different levels of E/M codes to indicate whether an office/outpatient visit took more time or required more complex medical decision making, “there no longer needs to be an add-on code to account for the additional resources required for more complex visits.” Similarly, the RUC — representing all clinical specialties, including primary care, surgeons, and other specialists — echoed the MedPAC concerns.

<sup>4</sup> See CY 2021 PFS Final Rule Utilization Estimates for EM Add-on Code available at <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1734-f>

<sup>5</sup> It should be noted that delaying the G2211 code did not cost Congress any additional funds. Similarly, if the G2211 code is halted again, Congress will not need to allocate any funds to accomplish this change.

The three-year Congressional moratorium on G2211 expires at the end of this year, and CMS is again proposing to move forward with its implementation. In the CY 2024 MPFS proposed rule, CMS estimates that G2211 is responsible for roughly 90% of the proposed budget neutrality reduction to the CF for 2024. Similar to the actions taken in the CAA, Congress can prevent CMS from implementing G2211, thereby mitigating 2% of the proposed cut to the 2024 CF at no cost to the Federal government, which would benefit all clinicians, including primary care and other office-based clinicians.

We believe G2211 remains duplicative of work already accounted for by existing codes, which have been updated and, if implemented, will inappropriately result in overpayments to those using it. The code is poorly defined, lacks detail regarding appropriate use, and is not resource-based. Furthermore, additional code sets, such as the chronic care management codes, have been implemented, which allow payment for primary care work that was previously unrecognized. At the same time, implementing G2211 will penalize clinicians who do not, or cannot, use it with yet another budget-neutrality-related reduction to the CF.

These year-over-year reductions to the CF caused by the application of budget neutrality continues to demonstrate that the Medicare physician payment system is broken. We urge you to halt implementation of G2211.

### **Healthcare Workforce**

Physicians are a vital component of our nation's health care infrastructure and we have seen firsthand the worsening shortage of health care providers surrounding the impact of the COVID-19 pandemic. A large portion of the physician workforce is also nearing traditional retirement age, which will soon contribute to the magnitude of national workforce shortages. Additionally, clinician burnout will contribute to when health professionals decide to retire.

The Association of American Medical Colleges (AAMC) seventh annual study on physician supply and demand projects the United States could see an estimated shortage of between 37,800 and 124,000 physicians by 2034, including shortfalls in both primary and specialty care. The same report highlights the impact to radiology by estimating shortages in "other specialties," including radiology, to range from 10,300-35,600 physicians.

Within the field of radiology, there are shortages of not just radiologists, but technologists and other support personnel. This is especially problematic because of the central role that radiology and minimally invasive image guided therapies (interventional radiology and radiation oncology) play in virtually every significant episode of health care. Shortages in radiology stem from both the number and complexity of exams and procedures, all of which improve patient care. Many of these procedures obviate the need for surgical intervention or prolonged therapies for patients. Radiology also plays an integral role in population health through screening and early detection

of disease or disease precursors. The role of this specialty in patient care is lifesaving, which ultimately saves the health care system money and benefits those in all communities—underserved, urban and rural.

While the data projecting shortages is stark, the threat of clinician burnout is just as real. According to the AAMC's 2019 National Sample Survey of Physicians, 40% of the country's practicing physicians felt burned out at least once a week before the COVID-19 crisis began—and the issue of increased clinician burnout could cause doctors and other health professionals to reduce their hours or retire sooner.

The trends in radiology track with the national data on the physician workforce. For example, the current radiologist population is skewed toward seasoned professionals who may be looking at retirement. Of the 20,970 radiologists engaged in active patient care, 82% are age 45 and over, while 53% are age 55 and over. A recent study also demonstrated that radiologists ranked fifth out of more than 23 surveyed specialties in their reported burnout rate. Increasing rates of burnout have been reported over several years. A 2020 Journal of Breast Imaging study found a high prevalence of burnout among breast imagers, particularly among early-career professionals.

With concerns about physician shortages, looming new shortages and the threat of burnout leading to more physicians leaving the workforce, investments to increase the number of physicians is sorely needed. ACR, along with the Graduate Medical Education (GME) Advocacy Coalition (Coalition), spearheaded by the AAMC, continue to advocate for additional Medicare funded GME residency slots. An increase in new GME residency positions is one approach to combat our nation's physician shortage and will be integral to the future of health care.

ACR appreciates the efforts by Congress to bolster the health care workforce, including passage of the Consolidated Appropriations Act of 2021, which added an additional 1,000 GME slots, the first increase of GME slots in 25 years, serving as an initial investment in addressing the projected shortage of 124,000 physicians by 2034. Yet, further congressional action is required to address access issues and ensure the physician workforce can meet the needs of an aging population. While this legislation is a step in the right direction and includes provisions that participating hospitals be located in rural areas, it places numerous other restrictions on eligibility for the new residency slots. First, approximately three-quarters of the new positions are for primary care and mental health specialties. In addition, the eligible hospitals must be currently training a number of residents in excess of their GME cap, be in states with new medical schools or branch campuses, or serve areas designated as health professional shortage areas (HPSAs). While there is a definite need to focus on mental health and psychiatry, several specialties are missing out on new residency slots. We recommend that Congress pass legislation to fund GME slots specifically designated for radiology.

ACR supports the Resident Physician Shortage Reduction Act, H.R. 2389. This legislation would expand the number of federally supported medical residency positions by 2,000 annually for seven years, directly addressing the growing physician shortage and improving health care access for all. We urge lawmakers to pass this bill during the 118th Congress.

In order to help enhance the distribution of these new positions, we urge the committee to include language specifying that if any category of hospitals cannot use their allotted slots, then these slots would be made available to hospitals in other categories. We also urge the committee to include language that would prevent the use of HPSA scores when determining priority for the provision of slots. As the Coalition emphasized during the Consolidated Appropriations Act distribution discussion of the 2021 GME slots, while HPSA scores are an accurate indicator of the need for a subset of practitioners in a given state, they do not speak to the ability of hospitals in those states to train additional residents or provide care for patients who live in HPSAs. It is our concern that the use of HPSA scores to prioritize the distribution of GME slots would disadvantage teaching hospitals that, although physically located outside of the boundaries of a HPSA, serve as the primary point of care for a HPSA population. This approach would provide for a broad distribution of slots to a diverse array of teaching hospitals and ensure hospitals that are best positioned to make immediate use of these new slots are able to do so.

ACR also supports the bipartisan Specialty Physicians Advancing Rural Care (SPARC) Act, H.R. 2761, introduced by Representatives John Joyce (R-PA) and Deborah Ross (D-NC). The bill would help address the shortage of physicians in rural communities by creating a student loan repayment program for specialist physicians practicing in rural areas.

Addressing the health care workforce challenges that we face requires educating and training enough physicians to meet the country's needs. A long-term investment is needed by Congress. ACR is committed to working with lawmakers and optimizing the radiology workforce as we explore legislative solutions to bring vital and innovative medical care to patients.

### **Innovative Models and Technology**

The ACR has long advocated for the full implementation of Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA) where Congress established the consultation of appropriate use criteria (AUC) by providers ordering advanced diagnostic imaging exams (AUC program). This innovative program is an effective and evidence-based system, founded on physician-developed guidelines that is intended to optimize patient care by guiding providers as to whether an advanced imaging study is appropriate and if so, which kind of study is most appropriate. The AUC program is housed within an Electronic Medical Record via clinical decision support (CDS) technology and has demonstrated improvement in the ordering of the correct imaging study in hundreds of institutions over several years. Entities using this AUC program have shown reductions in unnecessary utilization of imaging studies resulting in savings to both the institutions and copayment costs to patients.

While CMS has identified certain claims processing challenges and suggests pausing the AUC program in its July 2023 Medicare Physician Fee Schedule proposed rule, statutory changes can be made to improve this process and enable full implementation. The agency did reinforce the benefits of the program as well as indicate significant estimated savings (\$700,000,000 per year) associated with its eventual implementation. Recognizing that more and more advanced practiced nurses are filling the gap in rural and underserved areas where physicians are not always available due to increasing shortages, the AUC program will help ensure appropriate ordering of imaging and in turn, the best care for patients, as well as government savings.

### **Aligning Sites of Service**

ACR understands that Congress is exploring policies to equalize payments for identical care provided at different settings of care. While there are potential savings with some of these policies, advanced imaging has already been subjected to site neutral since the DRA of 2005. While the College does not currently have a position on site neutrality, we have concerns about the impact any such policy could have on departmental budgets and any unintended consequences that would affect patient care. We would welcome discussion with the committee on any forthcoming policies.

We thank you for the opportunity to respond to this request for information. Please consider us a resource, and if you have any questions, contact ACR Director of Government Affairs, [Ashley Walton](#).

Sincerely,



Cynthia R. Moran  
Executive Vice President  
American College of Radiology